



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COLLOM & CARNEY CLINIC
5002 COWHORN CREEK
TEXARKANA TX 75503

Respondent Name

SERVICE LLOYDS INSURANCE CO

Carrier's Austin Representative Box

Number 01

MFDR Tracking Number

M4-12-2321-01

MFDR Date Received

March 7, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Service Lloyds is not acknowledging original receipt of the following medical bill nor is Corvel accepting my documentation of proof of timely filing within the 95 days. I have attached proof from Stoneriver/P2P link showing P2P received this bill from our facility electronically on 7/13/11 in which they printed and mailed this bill to the address on the claim...I have attached my documentation showing that P2P link received this bill on 7/13/11 and mailed on 7/14/11. I am also attaching an email from P2P customer support where I confirmed the filing date of 7/13/11..."

Amount in Dispute: \$3945.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill for the services rendered on June 15, 2011 was not timely submitted by the health care provider. Additionally, the provider does not meet any of the exceptions for not timely submitting the bill in dispute...The provider has not submitted satisfactory proof that the initial billing was sent to the carrier within the 95-day rule..."

Response Submitted by: Harris & Harris

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 15, 2011	11012 27786-LT 27829-LT 28430-59-LT 99221-57	\$3945.00	\$2947.48

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical

fee dispute.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 29/RM2 – time limit for filing claim/bill has expired
- 57 – decision for surgery
- 59 – distinct procedural service
- 193 – original payment decision maintained

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
 - Review of the submitted information finds documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Requestor submitted a P2P confirmation document indicating the bill was sent on 7/14/2011. The requirements of 28 Texas Administrative Code §133.20(b) have been met.
 - Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute is due reimbursement for the services in dispute.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$2947.48.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of \$2947.48 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution

December 2012
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.